



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Robert Panzarella, M.D.

**Respondent Name**

Travelers Indemnity Company of Connecticut

**MFDR Tracking Number**

M4-17-1438-01

**Carrier's Austin Representative**

Box Number 5

**MFDR Date Received**

January 17, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "12/16/2016 A reduced payment in the amount of \$950.00 received... 01/11/2017 Contacted Travelers by phone and notified that Additional payment had been Denied."

**Amount in Dispute:** \$1,350.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Provider alleges they are entitled to full billed charges. At the outset, the Carrier would note that while the Provider billed for 12 units of 99456, the impairment rating calculation only addresses 11 body areas. Additionally, many of these individual 'body areas' are in fact part of the same non-musculoskeletal body systems as defined by the AMA Guides.

Consequently, the Carrier contends the Provider is not entitled to the full amount sought on the Table of Disputed Services. The Carrier calculates reimbursement as follows:

MMI Evaluation	\$350.00
ROM-Shoulder	\$300.00
ROM-Foot	\$150.00
Respiratory System (AMA Chap. 5)	\$150.00
-lungs	
Cardiovascular System (AMA Chap. 6)	\$150.00
-heart	
Hematoietic [sic] System (AMA Chap. 7)	\$150.00
-spleen	
Digestive System (AMA Chap. 10)	\$150.00
-liver, pancreas, kidneys, abdominal wall	
Endocrine System (AMA Chap. 12)	\$150.00
-adrenals	
<b>Total Reimbursement:</b>	<b>\$1,550.00</b>

Consequently, the Carrier is issuing supplemental reimbursement in the amount documented above. The Carrier disputes that the Provider is entitled to reimbursement of full billed charges."

**Response Submitted by:** Travelers

## ***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 2016	Designated Doctor Examination (99456-W5-WP), 12 units	\$1,350.00	\$150.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for maximum medical improvement and impairment rating provided on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
  - 863 – Reimbursement is based on the applicable reimbursement fee schedule.
  - TR99 – The billed service is under a Paradigm contract. Please submit your billing invoice to Paradigm Health Corp, 1277 Treat Blvd., Suite 800, Walnut Creek, CA 94597.
  - P12 – Workers' compensation jurisdictional fee schedule adjustment.
  - W3 – Additional payment made on appeal/reconsideration.
  - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.

### **Issues**

1. Are the insurance carrier's reasons for denial of payment based on coverage supported?
2. Is Robert Panzarella, M.D. entitled to additional reimbursement?

### **Findings**

1. Travelers Indemnity Company of Connecticut (Travelers) denied the disputed services on Explanation of Reimbursement dated October 26, 2016, with claim adjustment reason codes 109 – "CLAIM NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM TO THE CORRECT PAYER/CONTRACTOR," and TR99 – "The billed service is under a Paradigm contract. Please submit your billing invoice to Paradigm Health Corp, 1277 Treat Blvd., Suite 800, Walnut Creek, CA 94597."

The Division finds that Travelers did not maintain these denials in subsequent Explanations of Reimbursement or on its position statement. Therefore, the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Robert Panzarella, M.D. is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating for twelve units, performed on October 7, 2016. Per 28 Texas Administrative Code §134.250(3), "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$350.00.

28 Texas Administrative Code §134.250(4) states:

- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
  - (i) Musculoskeletal body areas are defined as follows:
    - (I) spine and pelvis;

- (II) upper extremities and hands; and,
- (III) lower extremities (including feet).
- (ii) The MAR for musculoskeletal body areas shall be as follows.
  - (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
  - (II) If full physical evaluation, with range of motion, is performed:
    - (-a-) \$300 for the first musculoskeletal body area; and
    - (-b-) \$150 for each additional musculoskeletal body area.
- (D) ...
  - (i) Non-musculoskeletal body areas are defined as follows:
    - (I) body systems;
    - (II) body structures (including skin); and,
    - (III) mental and behavioral disorders.
  - (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides...
  - (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation finds that Dr. Panzarella performed impairment rating evaluations that include physical examination and range of motion of the left shoulder and right ankle/foot. Submitted documentation also supports that Dr. Panzarella performed impairment rating evaluations of the lungs, liver, spleen, pancreas, adrenals, chest, kidneys, abdomen, and heart. The MAR for these examinations is calculated as follows:

Examination	AMA Chapter	\$134.204 Category	Reimbursement Amount
Maximum Medical Improvement			\$350.00
IR: Left Shoulder (ROM)	Musculoskeletal System	Upper Extremities	\$300.00
IR: Right Ankle/Foot (ROM)		Lower Extermities	\$150.00
IR: Lungs	Respiratory System	Body Systems	\$150.00
IR: Chest			
IR: Liver	Digestive System	Body Systems	\$150.00
IR: Pancreas			
IR: Abdomen			
IR: Spleen	Hematopoietic System	Body Systems	\$150.00
IR: Adrenals	Endocrine System	Body Systems	\$150.00
IR: Kidneys	Urinary System	Body Systems	\$150.00
IR: Heart	Cardiovascular System	Body Systems	\$150.00
<b>Total MMI</b>			<b>\$350.00</b>
<b>Total IR</b>			<b>\$1,350.00</b>
<b>Total Exam</b>			<b>\$1,700.00</b>

The total MAR for the disputed services is \$1,700.00. Travelers paid a total of \$1,550.00. An additional reimbursement of \$150.00 is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

## **ORDER**

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	Laurie Garnes _____ Medical Fee Dispute Resolution Officer	February 13, 2017 _____ Date
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## **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**